DATE OF REVIEW: 4/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Preauthorization for RS2m Muscle Stimulator and supplies.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a board certified orthopedic surgeon on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Dx Code	*Service Being Denied*	*Billing Mod*	*Type Review*	*DOS*	*Amt Billed*	*Date of Injury*	*DWC Claim #*	*Upheld / Overturned*
Headache	S1399		Prospective					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 3/30/07
2. Determination Notices – 2/5/07, 2/26/07
3. Email Regarding Preauthorization Denial - 3/26/07
4. Texas Department of insurance Division of Workers Compensation Hearing Information – 10/6/06
5. Prospective Review Medical Examination – 2/5/07
6. Patient 7-Day Progress Report – 11/15/06
7. MD Impairment Rating Examination – 5/15/06

PATIENT CLINICAL HISTORY:

This case concerns an adult male who sustained a work related injury on . Records indicate that while standing next to a metal door, the wind blew the door against his head which resulted in severe headaches. Diagnoses have included closed head injury, headaches, post concussion syndrome, cervical strain/sprain and mild degenerative spondylosis. Evaluation and treatment for this injury has included CT scan, medications, nerve blocks, and physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient has cervical strain and degenerative spondylosis. There is no class I data to support the use or efficacy of a muscle stimulator for chronic neck pain. A muscle stimulator is considered investigational for treatment of this patient's condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☒ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Van Tulder MW, et al. Outcome of non-invasive treatment modalities on back pain: an evidence-based review. Eur Spine J. 2006 Jan; 15 Suppl 1:S64-81.

Kroeling, P, et al. A Cochrane review of electrotherapy for mechanical neck disorders. Spine, 2005 Nov 1; 30(21): E641-8.